ALTA LIFE INSURANCE PLAN ENROLLMENT APPLICATION/CHANGE FORM FOR STATE OF FLORIDA PARTICIPATING AGENCIES:

- Agency for Health Care Administration, # 781019
- Department of Children & Families, # 749932
- Department of Elder Affairs, # 781018
- Department of Health, # 781020
- Department of Management Services, # 749852
- Department of State, # 749952
- Department of Veteran's Affairs, # 780102
- Florida Parole Commission, # 749992
- State Board of Administration, # 749942
- Department of Corrections, # 749902
- Department of Environmental Protection, # 749922
- Department of Juvenile Justice, # 780122
- Department of Revenue, # 780112
- Department of Transportation, # 780172
- Department of Administrative Hearings, 763851
- Office of the Auditor General, #749872

TO ALL FULL-TIME EMPLOYEES

This is your opportunity to enroll in our excellent, low-cost Group Term Life Insurance Plan sponsored by your Department.

- If you **ELECT TO HAVE COVERAGE**, complete and sign the **APPLICATION** (Section I).
- If you desire to make a **policy change** (beneficiary or name), complete and sign the **POLICY CHANGE (Section II)**,
- If you **are refusing coverage**, date and sign the **REFUSAL (Section III)**,
- All employees must return this form promptly to the Personnel Office, either **ACCEPTING OR REJECTING** coverage.

Attention: THIS FORM MUST REMAIN IN THE EMPLOYEE'S PERSONNEL FILE. DO NOT MAIL IT TO THE COMPANY.

I. APPLICATION FOR GROUP TERM LIFE INSURANCE COVERAGE

Employee Name _____ DOB _____ SSN _____

Employee ID# _____ Dept _____ Work Phone _____

Beneficiary Name _____ DOB _____ Relationship _____

Contingent Beneficiary Name _____ DOB _____ Relationship _____

I hereby apply for the amount of Group Term Life Insurance for which I am eligible under my employer's Group Insurance Plan. I authorize deductions from my earnings in the amount required to cover my premiums.

Employee Signature _____ Date _____

II POLICY CHANGE ONLY

Employee Name _____ DOB _____ SSN _____

Employee ID# _____ Dept _____ Work Phone _____

___ BENEFICIARY CHANGE

Change primary beneficiary to: _____
Last Name First Name Relationship

Change contingent beneficiary to: _____
Last Name First Name Relationship

___ NAME CHANGE

Change my name from _____ to _____

Employee Signature _____ Date _____

III

REFUSAL OF GROUP TERM LIFE INSURANCE PLAN: **I do not wish to enroll** in the Group Term Life Insurance Plan. I understand that if I later desire this coverage, I will be required to furnish, at my own expense, evidence of insurability satisfactory to Alta Health & Life Insurance Company.

Employee Signature _____ Date _____

IV FOR PERSONNEL USE ONLY

PLEASE FILE IN EMPLOYEE 'S PERSONNEL FILE. **DO NOT MAIL TO COMPANY**

Samas Code	District/div Code	Effective Date of insurance	Deduction Amount	Deduction Code	Date Processed/Initial
				262	